

## Notice Of Intent To Provide Public Access Defibrillation (PAD)

|  |                                     |
|--|-------------------------------------|
| Name of Entity Providing PAD   | Phone Number<br><br>(     )       - |
| Address<br><br>City:                                  State                                  Zip | Fax<br><br>(     )       -          |

**Type of Entity:** Please Check Appropriate boxes

|  |                            |  |                    |  |                        |
|--|----------------------------|--|--------------------|--|------------------------|
|  | Business                   |  | Industrial Setting |  | Construction Company   |
|  | Fire Department / District |  | Police Department  |  | Recreational Facility  |
|  | Local Municipal Government |  | County Government  |  | State Government       |
|  | School K-6                 |  | School 6-12        |  | College / University   |
|  | Physician's Office         |  | Medical Clinic     |  | Other Medical Facility |
|  | Nursing Home               |  | Adult Residence    |  | Other (Specify)        |

|   |                                     |
|---|-------------------------------------|
| <b>Name of Emergency Health Care Provider</b> (MD or Hospital) (If Hospital provide contact name) | Phone Number<br><br>(     )       - |
| Address<br><br>City:                                  State                                  Zip  | Fax<br><br>(     )       -          |

|  |         |
|--|---------|
| Name of Ambulance Service or 911 Dispatch Center Advised of PAD Program: | County: |
|--|---------|

**Name of PAD Training Program** (Please Check Appropriate Box)

|   |                               |                          |                         |                          |                                |
|---|-------------------------------|--------------------------|-------------------------|--------------------------|--------------------------------|
| Name of First Aid Training Program (Please Check Appropriate Box) |                               |                          |                         |                          |                                |
| <input type="checkbox"/>  | American Heart Association    | <input type="checkbox"/> | American Red Cross      | <input type="checkbox"/> | American Safety & Health Inst. |
| <input type="checkbox"/>  | Emergency Services Inst.      | <input type="checkbox"/> | National Safety Council | <input type="checkbox"/> | REMSCO of NYC, Inc             |
| <input type="checkbox"/>  | Medic First Aid International |                          |                         |                          |                                |

|                          |               |  |                 |   |
|--------------------------|---------------|--|-----------------|---|
| Manufacturer of AED Unit | Model of AED: | Number of PAD trained Providers in Organization: | Number of AEDs: | Number of buildings AEDs to be placed in: |
|--------------------------|---------------|--|-----------------|---|

**Authorization Names & Signatures:**

|                                |      |  |      |
|--------------------------------|------|--|------|
| CEO or Designee (Please Print) | Date | MD or Hospital Representative (Please Print) | Date |
| Signature                      |      | Signature                                    |      |

**Complete this form and send it with your completed collaborative agreement to the Regional EMS Council for your area.**